

**WEST**

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L5: Entry 1 of 2

File: USPT

Aug 21, 2001

DOCUMENT-IDENTIFIER: US 6277071 B1  
TITLE: Chronic disease monitor

US PATENT NO. (1):  
6277071

Detailed Description Text (5):

Patient record 16 also include test data 106. Test data 106 comprises the office visit date, practitioner, office visit comments, such as progress notes and patient concerns, are recorded. Clinical information, i.e. weight, height, blood pressure, smoking status, blood glucose recordations (SMBG), lipids profile, liver enzyme, foot exams, neuropathy, skin condition, eye exam, are stored. It will be appreciated to those skilled in the art, the blood glucose information may be entered manually or electronically transferred from a blood glucose metering device 20, such as a Life Scan OneTouch. Data may also be transferred directly from a laboratory, such as via an RS-232 port or TCP/IP (FIG. 1) in HL7 (or other standard data format). Quality of life indicators, such as number of emergency room visits, days of hospitalization, days lost from work, and activities, provide important outcome information. By storing this information in patient record 16, reports may be generated comparing changes in these factors over a given period of time and/or for a selected treatment therapy. Combinations may be applied. Further, a patient's own self assessment is recorded as diabetes is such that success in treatment is heavily dependant on the patient's active participation.

Detailed Description Text (9):

FIG. 5 illustrates a window which is prompted when office visit data is entered into patient record 16. The user may enter the office visit date, practitioner, weight, height, blood pressure, smoking status, blood glucose (SMBG) and daily range, foot exam (PVD, neuropathy, poor skin condition, podiatric referral), quality of life indicators (number of emergency room visits, days of hospitalization, days lost from work) and the patient self assessment. FIG. 6 illustrates a window which is prompted for the creation of a patient quality plan 110. The tests to be preformed on the patient are selected for enablement, frequency, alert (where a value is exceeded), threshold and goal. As described in greater detail below, the values for the threshold default to the guideline value located in guideline 14 generated for the patient population in risk manager 24. The user may enter a different value for a given threshold and override the guideline default. The user is prohibited from entering a threshold value which would be impossible (outside of permissible test ranges, for example) and which is greater than the patient population threshold. FIG. 7 illustrates a current therapy plan data record in patient record 16 as presented to the user in a window format. The user may input comments. The information is classified by medication type, medication, dosage, frequency and start date. The nutrition plan summary and/or exercise plan summary may also be entered.

**WEST****End of Result Set**

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L5: Entry 2 of 2

File: USPT

Oct 20, 1998

DOCUMENT-IDENTIFIER: US 5823948 A

TITLE: Medical records, documentation, tracking and order entry system

US PATENT NO. (1):5823948Detailed Description Text (134):

A set of wound treatment screens provides a method for documenting multiple layers of repair using different suture techniques on different tissue layers with different suture material.